

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 33418

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

FILED OCT 19 1943 318

Registration District No. ....

Primary Registration District No. 1003

Registrar's No. 8823

1. PLACE OF DEATH:

(a) County.....  
(b) City or town St. Louis, Missouri  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Homer G. Phillips Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 11 days  
In this community 58 years  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME

John Penn

3. (b) If veteran, name war.....

3. (c) Social Security No. 1-1-1-1

4. Sex Male 5. Color or race Col 6. (a) Single, widowed, married, divorced Single  
6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years (Month) (Day) (Year)

7. Birth date of deceased Feb 2 1964  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
79 8 2 hr. min.

9. Birthplace Pike County, Mo  
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business Franklin nut Co

12. Name Not known

13. Birthplace Not known  
(City, town, or county) (State or foreign country)

14. Maiden name Not known

15. Birthplace Not known  
(City, town, or county) (State or foreign country)

16. Informant Johnnie Bolodry Payer

(b) Address 1412 Forest

17. (a) Burial (b) Date thereof 10-7-43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Greenwood

18. (a) Signature of funeral director W. J. Schorn

(b) Address 2625 S. 2nd St.

19. (a) Oct 6 1943 (b) J. P. Brineck  
(Date received local health officer's certificate) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County.....  
(c) City or town St. Louis,  
1008 N. 14th St.  
(If outside city or town limits, write "RURAL")  
(d) Street No..... (If rural, give location)  
(e) Citizen of foreign country?..... (Yes or No)  
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 3,  
year 1943 hour 3 minute 05 A.M.

21. I hereby certify that I attended the deceased from September 22, 1943 to October 3, 1943;  
that I last saw him alive on October 3, 1943;  
and that death occurred on the date and hour stated above.

Immediate cause of death.....  
Bronchopneumonia Terminal

Due to Carcinoma of Prostate Gland Unk.

Due to.....

Other conditions.....  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations.....

Of autopsy.....

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify).....  
(b) Date of occurrence.....  
(c) Where did injury occur?..... (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?.....

While at work?..... (Specify type of place)  
Means of injury.....

23. Signature A. K. Fleish (M. D. or other)

Address 2601 Whittier Date signed 10/4/43

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed

*W. Richardson*

Licensed Embalmer No. *2928*

P. O. Address. *2625 Glasgow*

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**